APPENDIX 3
INSTRUCTIONS FOR THE COMPLETION OF THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

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ELEMENT 1 - PROCESSING TYPE
Enter the appropriate three-digit processing type from the list below. The "process type" is a three-digit code used to identify a category of service requested. <u>Use 999 - "Other" only if the requested category of service is not found in the list</u>. Prior Authorization and Spell of Illness requests will be returned without adjudication if no processing type is indicated.

**111 - Physical Therapy
**112 - Occupational Therapy
**113 - Speech Therapy/Audiology
**114 - Physical Therapy (spell of illness only)
**115 - Occupational Therapy (spell of illness only)
**116 - Speech Therapy (spell of illness only)
117 - Physician Services (includes Family Planning Clinic and Rural Health)
118 - Chiropractic
*120 - Home Health/Independent Nurse Services/Home Health Therapy
121 - Personal Care Services
122 - Vision
126 - Psychotherapy (HCFA 1500 billing providers only)
127 - Psychotherapy (UB-82 billing providers only)
128 - AODA Services (other than Day Treatment)
129 - Mental Health Day Treatment Services (not AODA Day Treatment)
130 - Durable Medical Equipment
131 - Drugs
132 - Disposable Medical Supplies
133 - Transplant Services
134 - AIDS Services (hospital and nursing home)
135 - Ventilator Services (hospital and nursing home)
136 - AODA Day Treatment
999 - Other (use only if the requested category of service is not listed above)

* Includes PT, OT, Speech
** Includes Rehabilitation Agencies

ELEMENT 2 - RECIPIENT'S MEDICAL ASSISTANCE IDENTIFICATION NUMBER
Enter the recipient's ten-digit Medical Assistance identification number as found on the recipient's Medical Assistance identification card.

ELEMENT 3 - RECIPIENT'S NAME
Enter the recipient's last name, followed by first name and middle initial, exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 4 - RECIPIENT'S ADDRESS
Enter the address of the recipient's place of residence; the street, city, state, and zip code must be included. If the recipient is a resident of a nursing home or other facility, also include the name of the nursing home or facility.

ELEMENT 5 - RECIPIENT'S DATE OF BIRTH
Enter the recipient's date of birth in MM/DD/YY format (e.g., June 8, 1941, would be 06/08/41), as it appears on the recipient's Medical Assistance identification card.

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ELEMENT 6 - RECIPIENT'S SEX
Enter an "X" to specify male or female.

ELEMENT 7 - BILLING PROVIDER'S NAME, ADDRESS AND ZIP CODE
Enter the name and complete address (street, city, state, and zip code) of the billing provider. **No other information should be entered in this element since it also serves as a return mailing label.**

ELEMENT 8 - BILLING PROVIDER'S TELEPHONE NUMBER
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider.

ELEMENT 9 - BILLING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER
Enter the eight-digit Medical Assistance provider number of the billing provider.

ELEMENT 10 - RECIPIENT'S PRIMARY DIAGNOSIS
Enter the appropriate International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis code and description most relevant to the service/procedure requested.

NOTE: Pharmacists, medical vendors, and individual medical suppliers may provide a written description only.

ELEMENT 11 - RECIPIENT'S SECONDARY DIAGNOSIS
Enter the appropriate International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis code and description additionally descriptive of the recipient's clinical condition.

NOTE: Pharmacists, medical vendors, and individual medical suppliers may provide a written description only.

ELEMENT 12 - START DATE OF SPELL OF ILLNESS
DO NOT COMPLETE THIS ELEMENT UNLESS REQUESTING A THERAPY (PT, OT, SPEECH) SPELL OF ILLNESS. Enter the date of onset for the spell of illness in MM/DD/YY format (e.g., March 1, 1988, would be 03/01/88).

ELEMENT 13 - FIRST DATE OF TREATMENT
DO NOT COMPLETE THIS ELEMENT UNLESS REQUESTING A THERAPY (PT, OT, SPEECH) SPELL OF ILLNESS. Enter the date of the first treatment for the spell of illness in MM/DD/YY format (e.g., March 1, 1988, would be 03/01/88).

ELEMENT 14 - PROCEDURE CODE(S)
Enter the appropriate Revenue, HCPCS, or National Drug Code (NDC) procedure code for each service/procedure/item requested, in this element. DO NOT COMPLETE THIS ELEMENT IF REQUESTING A THERAPY (PT, OT, SPEECH) SPELL OF ILLNESS.

ELEMENT 15 - MODIFIER
Enter the modifier corresponding to the procedure code (if a modifier is required by WMAP policy and the coding structure used) for each service/procedure/item requested. DO NOT COMPLETE THIS ELEMENT IF REQUESTING A THERAPY (PT, OT, SPEECH) SPELL OF ILLNESS.

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ELEMENT 16 - PLACE OF SERVICE

Enter the appropriate place of service code designating where the requested service/procedure/item would be provided/performed/dispensed.

Code	Description
0	Other
1	Inpatient Hospital
2	Outpatient Hospital
3	Office
4	Home
7	Nursing Home
8	Skilled Nursing Facility
9	Ambulance

Alpha	Description
A	Independent Lab
B	Ambulatory Surgical Center

NOTE: Mental health services may not be provided in the recipient's home (POS 4).

ELEMENT 17 - TYPE OF SERVICE

Enter the appropriate type of service code for each service/procedure/item requested. DO NOT COMPLETE THIS ELEMENT IF REQUESTING A THERAPY (PT, OT, SPEECH) SPELL OF ILLNESS.

Numeric	Description
0	Blood
1	Medical (including: Physician's Medical Services, Home Health, Independent Nurses, Audiology, PT, OT, ST, Personal Care, AODA, Day Treatment, and AODA Day Treatment)
2	Surgery
3	Consultation
4	Diagnostic X-Ray - Total Charge
5	Diagnostic Lab - Total Charge
6	Radiation Therapy - Total Charge
7	Anesthesia
8	Assistant Surgery
9	Other including: Transportation *Non-MD Psych Family Planning Clinic Rehabilitation Agency Nurse Midwife Chiropractic

* non-Board operated only

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Alpha	
B	Diagnostic Medical - Total
C	Ancillaries, Hospital and Nursing Home
D	Drugs
E	Accommodations, Hospital and Nursing Home
F	Free Standing Ambulatory Surgical Center
G	Dental
J	Vision Care and Cataract Lens
K	Nuclear Medicine - Total Charge
P	Purchase New DME
Q	Diagnostic X-Ray - Professional
R	DME Rental
S	Radiation Therapy - Professional
T	Nuclear Medicine - Professional
U	Diagnostic X-Ray, Medical - Technical
W	Diagnostic Medical - Professional
X	Diagnostic Lab - Professional

ELEMENT 18 - DESCRIPTION OF SERVICE
Enter a written description corresponding to the appropriate Revenue, HCPCS or National Drug Code (NDC) procedure code for each service/procedure/item requested.

NOTE: If you are requesting a therapy spell of illness, enter "Spell of Illness" in this element.

When requesting home health/personal care services, indicate the number of hours per day/number of days per week times the total number of weeks being requested.

ELEMENT 19 - QUANTITY OF SERVICE REQUESTED
Enter the quantity (e.g., number of services, dollar amount) requested for each service/procedure/item requested.

AODA (number of services)
AODA Day Treatment (number of hours)
Audiology (number of services)
Chiropractic (number of adjustments)
Day Treatment (number of services)
Dental (number of services)
Disposable Medical Supplies (number of days supply)
Drugs (number of days supply)
Durable Medical Equipment (number of services)
Hearing Aid (number of services)
Home Health (number of units)/Independent Nurses (number of units)
Home Health Therapy-PT, OT, Speech (number of visits)
Hospital Transplant (per hospital stay)
Hospital and Nursing Home AIDS Services (number of days)
Hospital and Nursing Home Ventilator Services (number of days)
Occupational Therapy (number of services)

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Occupational Therapy (spell of illness only) (enter 35)
Orthodontics (dollar amount)
Personal Care (number of hours)
Physical Therapy (number of services)
Physical Therapy (spell of illness only) (enter 35)
Physician (number of services)
Psychotherapy (HCFA 1500 billing providers only) (number of services)
Psychotherapy (UB-82 billing providers only) (dollar amount)
Speech Therapy (number of services)
Speech Therapy (spell of illness only) (enter 35)
Transportation (number of services) (mileage)
Vision (number of services)

NOTE: If requesting a therapy spell of illness, enter "35" in this element.

ELEMENT 20 - CHARGES
Enter your usual and customary charge for each service/procedure/item requested. If the quantity is greater than "1", multiply the quantity by the charge for each service/procedure/item requested. Enter that total amount in this element. DO NOT COMPLETE THIS ELEMENT IF REQUESTING A THERAPY (PT, OT, SPEECH) SPELL OF ILLNESS.

NOTE:
The charges indicated on the request form should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to Terms of Provider Reimbursement issued by the Department of Health and Social Services.

ELEMENT 21 - TOTAL CHARGE
Enter the anticipated total charge for this request. DO NOT COMPLETE THIS ELEMENT IF REQUESTING A THERAPY (PT, OT, SPEECH) SPELL OF ILLNESS.

ELEMENT 22 - BILLING CLAIM PAYMENT CLARIFICATION STATEMENT
"An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO."

ELEMENT 23 - DATE
Enter the month, day, and year (in MM/DD/YY format) the prior authorization request form was completed and signed.

ELEMENT 24 - REQUESTING PROVIDER'S SIGNATURE
The signature of the provider requesting/performing/dispensing the service/procedure/item must appear in this element.

DO NOT ENTER ANY INFORMATION BELOW THE SIGNATURE OF THE REQUESTING PROVIDER – THIS SPACE IS RESERVED FOR THE WISCONSIN MEDICAL ASSISTANCE PROGRAM CONSULTANT(S) AND ANALYST(S).